UTAH DEPARTMENT OF HEALTH

Medically Complex Children's Waiver (MCCW) Application Instructions

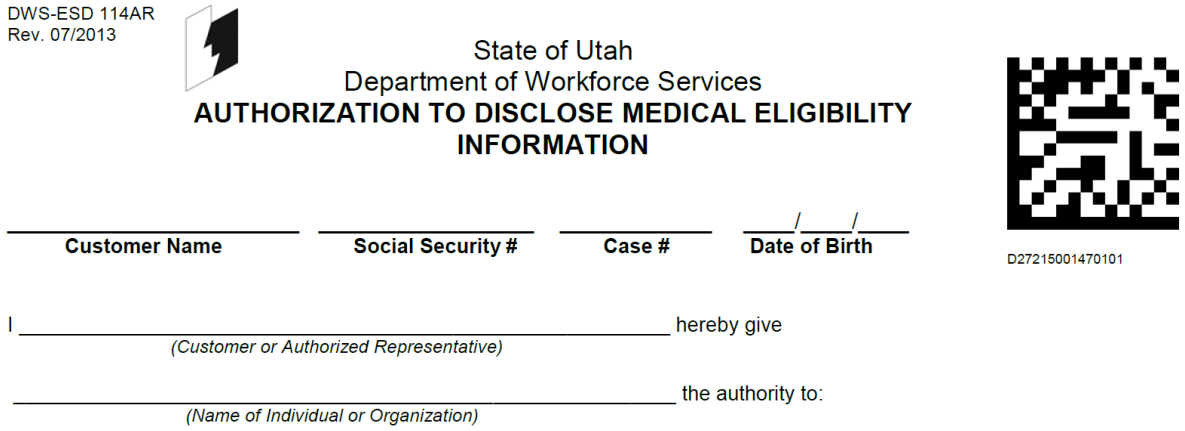
This power point is to be used as a guide for the application to the Medically Complex Children's Waiver

General Instructions

- The application must be submitted along with:
  - Well Child Check or Physical Exam; these records must be comprehensive and support all marked selections on the application.
  - Medicaid Disability Addendum form 354
  - Authorization to Disclose Medicaid Eligibility Information form 114AR
- If the submitted application does not include all of the above it will be returned.

General Instructions

- The medical records submitted must support each item marked on the application. It is recommended that you compare your application against medical records you intend to submit for inconsistencies.
- You must include an Authorization to Disclose Medical Eligibility Information form (114AR).



DWS-ESD 114AR
Rev. 07/2013

State of Utah
Department of Workforce Services
AUTHORIZATION TO DISCLOSE MEDICAL ELIGIBILITY INFORMATION

Customer Name	Social Security #	Case #	Date of Birth
			____/____/____

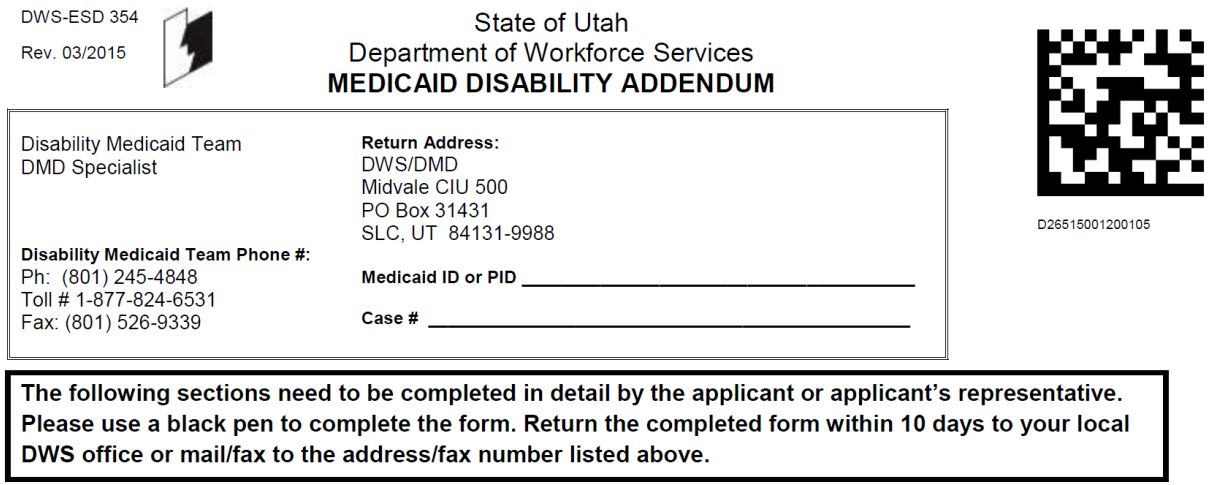
D27215001470101

I _____ hereby give
(Customer or Authorized Representative)

_____ the authority to:
(Name of Individual or Organization)

General Instructions

- The application must include the Medicaid Disability Addendum (354)



DWS-ESD 354
Rev. 03/2015

State of Utah
Department of Workforce Services
MEDICAID DISABILITY ADDENDUM

D26515001200105

Disability Medicaid Team
DMD Specialist

Return Address:
DWS/DMD
Midvale CIU 500
PO Box 31431
SLC, UT 84131-9988

Disability Medicaid Team Phone #:
Ph: (801) 245-4848
Toll # 1-877-824-6531
Fax: (801) 526-9339

Medicaid ID or PID _____

Case # _____

The following sections need to be completed in detail by the applicant or applicant's representative. Please use a black pen to complete the form. Return the completed form within 10 days to your local DWS office or mail/fax to the address/fax number listed above.

Frequent Medical Intervention and Consultation

- Please list all Specialty Physician's involved in the care of your child. Please do not include their Primary Care Provider or Dental Provider; It is expected that all children would have these providers.

Frequent Medical Intervention and Consultation

Please provide a list of your child's specialty physicians below (these are physicians who are in addition to your primary care physician). If additional lines are required please attach a separate sheet:

Physician Name:	_____	*Specialty*	*Phone Number*
Physician Name:	_____	*Specialty*	*Phone Number*
Physician Name:	_____	*Specialty*	*Phone Number*
Physician Name:	_____	*Specialty*	*Phone Number*
Physician Name:	_____	*Specialty*	*Phone Number*

Condition/ Diagnosis

- Please list all of the condition's/ diagnosis your child has received. Please use an additional sheet if needed. All conditions listed must be verifiable through the medical records submitted with the application.

Please provide a list of your child's conditions/diagnoses below. If additional lines are required please attach a separate sheet:

Condition/Diagnosis _____

Condition/Diagnosis _____

Condition/Diagnosis _____

Frequent Medical Intervention

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- Please mark all that apply for the past 24 months

If your child has experienced any of the following in the past 24 months, please indicate below.

Please Check ALL that Apply

☐ **10 or more days in an inpatient facility**
This can include any days spent in an inpatient hospital, or skilled nursing facility during the past 24 months where the stay was related to the child's complex medical condition.

☐ **8 or more emergency department or outpatient visits**
This can include any visits to the emergency room as well as any outpatient procedures performed during the last 24 months where the visit was related to the child's complex medical condition.

☐ **20 or more physician visits or phone calls**
This can include office visits to any physician (including primary care and specialists) and also include visits to the urgent care in the last 24 months where the visit was related to the child's complex medical condition.

Device Based Supports

- The submitted medical records must support the device's marked on your application. ie. If you mark Tracheostomy we must be able to verify it via the records submitted.

Device Based Supports

Prolonged dependence (more than 3 months) on medical devices to compensate for inadequate organ function. Please do not respond to these based on periods of increased illness as it is anticipated that all applicant's needs will temporarily increase during these periods.

Please Check ALL that Apply

- ☐ **Tracheostomy – including humidification**
- ☐ **Daily non-invasive ventilation; or pressure support through tracheostomy (BiPAP, CPAP, etc.)**
- ☐ **Daily oxygen use**
- ☐ **Nasal, oral, pharyngeal, or tracheal suctioning 4 or more times per day**
- ☐ **Nasal, oral, pharyngeal, or tracheal suctioning 3 or fewer times per day**
- ☐ **Daily cough assist, or daily CPT vest or manual CPT treatments**
- ☐ **Shunts, pumps (e.g. insulin, baclofen, etc.), VNS, etc.**
- ☐ **Monitors – cardiorespiratory, pulse oximeter, apnea, glucose, etc.**

High Utilization of Medical Therapies, Treatments or Sub- specialty Services

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- The submitted medical records must support the device's marked on your application. ie. If you mark your child is incontinent the submitted documentation must verify it.

High Utilization of Medical Therapies, Treatments or Sub-specialty Services

Prolonged dependence (more than 3 months) on any of the following.

Please Check ALL that Apply

- ☐ Central Venous Catheter (PICC Line, Hickman, etc.)
- ☐ Urinary Catheter (vesicostomy, indwelling or intermittent)
- ☐ Colostomy or complex bowel program
- ☐ Daily bowel or bladder incontinence (child must be greater than 3 years of age)
- ☐ Daily wound care or sterile dressing changes (does not include trach, IV, stoma or feeding tube sites)
- ☐ Tube Feeding (bolus OR continuous)
- ☐ Severe seizures requiring at least minimal intervention one or more times per month
- ☐ Occupational Therapy at least monthly
- ☐ Physical Therapy at least monthly
- ☐ Speech Therapy at least monthly
- ☐ My child is deaf and/or blind
- ☐ Daily prolonged oral feedings lasting more than 30 minutes

Daily prolonged oral feeding includes not able to self-feed, arching or stiffening during feeding, refusal of feeding, texture aversion, difficulty chewing, coughing or gagging, frequent spitting or vomiting, excessive food drooling, etc.

Medications

- The medications listed must be documented in the medical records submitted. Please indicate if your child receives 5 or more doses in a 24 hour period.

☐ **Daily administration of 5 or more routine medications**

Daily administration of medication does not include any medications that are PRN or medications prescribed to be taken "as needed" and should include all administration routes.

Medication Name: _____ _____

Times Per Day

Medication Name: _____ _____

Times Per Day

Medication Name: _____ _____

Times Per Day

Devices

- List any devices related to mobility, these devices must be listed in the submitted medical records.

☐ **Daily use of braces, AFO's, wheelchairs, shower chairs, gait belts, or other mobility related devices**

Daily use of other devices includes any device not already specified in the application.

Device Name: _____

Device Name: _____

Device Name: _____

Device Name: _____

Device Name: _____

Mobility

- The records submitted must verify the mobility as marked on the application.

Please select the item below that best describes your child's mobility.

☐ **My child is completely immobile**
Non-ambulatory and is not able to make slight changes in positioning without assistance, cannot transfer to a chair and maintains a lying position.

☐ **My child's mobility is very limited**
Able to make slight changes in body or extremity position but unable to make frequent or significant changes without assistance. Cannot bear own weight and/or must be assisted into the chair or wheelchair.

☐ **My child's mobility is slightly limited**
Makes frequent though slight changes in body or extremity position independently. Walks or crawls occasionally during the day, but for very short distances, with or without assistance.

☐ **My child's mobility is not limited**
Walks or crawls frequently (at least every 2 hours) and is able to reposition without assistance.

Caregiver Impact

- Please indicate how caregiving for a Medically Complex Child has impacted family caregivers and finances in the last 24 months.

1. How often does the child sleep 6 hours or more, without requiring care?

☐ **Often (4 or more times per week)**

☐ **Sometimes (2 or more times per week)**

☐ **Seldom or Never (1 or fewer times per week)**

2. How often does the primary care giver engage in activities outside of the home without the applicant?

☐ **Often (1 or more times per week)**

☐ **Sometimes (2 or more times per month)**

☐ **Seldom or Never (less than 1 time per month)**

Additional Questions

- Contact us at mccw@Utah.gov
- Call us at:
  - Salt Lake 801-538-6155 option 5
  - Toll Free 800-662-9651 option 5